HOW EFFECTIVE IS CHILD-CENTERED PLAY THERAPY?

by

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ABSTRACT

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How Effective is Child-Centered Play Therapy?

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A variety of therapeutic interventions appear to be effective when used with children who are struggling with issues such as divorce, abuse, neglect, grief, family violence, and severe trauma. Due to the developmental differences between children and adults, children need an alternative approach to conventional talk therapy to meet their needs. Client-centered play therapy is a unique therapeutic process that allows the children to act out circumstances that are confusing, scary, and bothersome to them (Moustaka, 1973). The play

therapist recognizes the child's wants, needs, behaviors, and feelings, which are expressed through play. Each toy selected by the child is a representation of what he/she is trying to communicate (Landreth, 2002).

The purpose of this study was to determine the effectiveness of child-centered play therapy. Sixteen elementary students from the Migisi Day Treatment program at Marriage and Family Health Services, Ltd, in Eau Claire and Mondovi, Wisconsin, voluntarily participated in the study. In the experimental group, each subject received an hour of client-centered play therapy, whereas subjects in the control group did not. The subject's behaviors were observed and rated by filling out the Behavior Rating Index for Children (BRIC) instrument, which inquires about the subject's behavioral problems at a particular moment in time. In the control group, each subject's behaviors were observed and rated twice, with two hours in between each rating. In the experimental group, each subject's behaviors were observed and rated right before and an hour after their client-centered play therapy session.

Independent sample t-tests were used in this study. Analysis the post-test scores of the BRIC suggested that for the subjects who received an hour of client-centered play therapy, their change score decreased by six points. For the subjects who did not receive an hour of client-centered play therapy, their change score elevated fifteen points. Also, the experimental subjects were less likely to quit a job or task without finishing it than those in the control group. Plus, the experimental subjects were less likely to cheat on games, activities, and written

assignments compared to the subjects who were not exposed to an hour of child-centered play therapy.

In the future, replication of this research with a wider pool of subjects perhaps internationally, using a pre-test post-test design, or exposing the experimental group to the client-centered play therapy for a longer period of time is recommended.

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CHAPTER I: INTRODUCTION

Most of the time it is easy to know when a child may need some extra support and guidance from an adult. Sometimes, though, it is challenging to know when a child may be sad, scared, worried, or upset and asking in a non-verbal way for support or guidance. At times a child may need more than a caregiver can provide and may benefit from a counseling session.

Play is the language of children. While adults use words as tools to communicate, children use play materials symbolically to represent their changing world (Landreth, 1993). Using different materials as tools, a child expresses and gains mastery during the play therapy session. Just as a child enjoys having the same story read several times, so the child replays the problematic themes until, with the help of a play therapist, resolution and mastery are achieved (Axline, 1947).

Play therapy benefits children of all ages and those involved in the lives of children. It promotes symptom resolution, stability, and competence (Thompson & Rudolph, 1992). For children with behavior problems, such as aggressiveness and acting out, abuse, neglect, low self-esteem, stress, anxiety, family instability, difficulty with social and emotional adjustment, and many other problems, play therapy has proven to be effective (Fall, 1999).

There are a variety of play therapy modalities therapists' use when counseling children, such as cognitive-behavioral play therapy, Adlerian play therapy, filial play therapy, and child-centered play therapy. Cognitive-behavioral play therapy is an active intervention in which the therapist and child work

together in establishing goals and choosing play materials and activities. The therapist may be part "educator" in that new skills are taught to the child (Thompson & Rudolph, 1992). Kottman (1995) states that, in Adlerian play therapy, goals of misbehavior are the point of focus (Landreth, Baggerly, &Tyndall-Lind, 1999). Filial play therapy involves the parents/guardians directly in the play process working towards the goals of improving parenting skills and parent-child relationship (O'Connor & Braverman, 1997).

In child-centered play therapy the child is the main focus. The goal of child-centered play therapy is to help children work through their suppressed feelings that may be causing them to misbehave or act out at school or home (Fall, 1999). Children are always communicating verbally. However; they also communicate with their bodies, play, and total selves. Verbalization of stories, descriptions, thoughts, feelings, insights, issues, concerns, or problems are not required or expected of the children. The child's communication through play is considered acceptable and sufficient. The therapist does not judge, disagree, or deny what the child states to be true. The therapist's job is to understand the child's nonverbalized feelings and play (Landreth, Baggerly, & Tyndall-Lind, 1999).

Statement of the Problem

The effectiveness of child-centered play therapy has been shown in studies (Fall, 1999; Griffith, 1997; Wilson & Ryan, 2001). The majority of the research conducted on the efficacy of child-centered play therapy has been in a

case study format (O'Connor & Braverman, 1997). However, there has been minimal research conducted in the format of a control group and a experimental group because of the difficulty finding comparable samples of children and competent therapists (Schaefer & O'Connor, 1983). The research on the process and outcomes of child-centered play therapy has been minimal. This makes it difficult to draw any types of conclusions on the efficacy of child-centered play therapy techniques (Johnson, Rasbury, & Siegel, 1986).

Purpose of the Problem

The purpose of this study was to measure the effectiveness of child-centered play therapy. After thoroughly reviewing the literature on the efficacy of child-centered play therapy, additional research is needed. Therefore, an experimental research study with a control group will be purposely conducted.

Hypotheses

There are eleven null hypothesis proposed in this study. They are as follows:

Ho1: There will be no statistically significant difference within the sample scores on the Behavior Rating Index for Children a) between a control group and an experimental group at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-test for, b) the experimental group nor, c) the control group.

Ho2: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with hiding thoughts from other people at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Ho3: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with saying or doing really strange things at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Ho4: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with not paying attention when he/she should at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Ho5: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with quitting a job or task without finishing it at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Ho6: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with hitting, pushing, or hurting someone at the

post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Ho7: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with getting along poorly with other people at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Ho8: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with getting very upset at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Ho9: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with feeling sick at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Ho10: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with cheating at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Ho11: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with losing his/her temper at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

Assumptions of the Study

The researcher assumes the following:

1. The raters will score the instrument honestly;
2. The subject's behaviors will improve after an hour of child-centered play therapy;
3. The subjects will test limits in the play room;
4. The subjects will enjoy the play therapy session; and
5. One hour of play therapy will be enough to change the child's behavioral problems on the post-test measure of the BRIC.

Definitions of Terms

There are three terms that need to be defined for clarity of understanding. These terms are:

Child-Centered therapy- "an opportunity that is offered to the child to experience growth under the most favorable conditions, that is, by playing out feelings as he brings them to the surface, faces them, learns to control them, or abandons them. The child begins to realize the power within himself to be an

individual in his own right, to think for himself, to make his decisions, to become psychologically more mature, and, by so doing, to realize selfhood" (Axline, 1947, p.16).

Play therapy- is a "cluster of treatment modalities that involve the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development and the re-establishment of the child's ability to engage in play behavior (O'Connor, 2000, p.7).

Trichotillomania- is the "abnormal desire to pull out one's hair" (New Lexicon Webster's Dictionary, 1989, p.1053).

Limitations of the Study

The findings of this study may be limited by the following:

1. Raters may have felt pressured to respond in a certain way, thus, answering dishonestly;
2. There were limited amount of subjects (two girls and ten boys) in this study;
3. All subjects who participated in this study were attending the Marriage & Family Health Services, Migisi Day Treatment Program. As a result, the subjects may not be representative of the population as a whole.
4. The experimental subjects were only allowed one, one hour client-centered play therapy session; and

5. The control subjects were involved in the daily therapeutic milieu while the experimental subjects received play therapy.

Methodology

This study first provides an overview of the literature on child-centered play therapy. The first section discusses the process of play therapy and focuses on the play toys and materials. The next section discusses limit setting for client-centered play therapy. The final section discusses research-based articles that focus on the outcomes of child-centered play therapy.

The study's methodology provides a description of the subjects and how they were chosen and is followed by a description of the instrumentation used. In addition, procedures, data analysis, and data collection are described, along with a discussion of the methodological limitations. A description of the statistics used to analyze the data is given in table format. The pre-test and post-test research questions are related to the subject's behavioral problems towards either him/herself or his/her peers and are analyzed by staff. The study concludes with a discussion of the results, conclusions, and implications that were drawn from the research findings, followed by recommendations for future research.

CHAPTER II: LITERATURE REVIEW

Introduction

The purpose of chapter two is to provide an overview of the literature on child-centered play therapy. The first section discusses the three main concepts of the personality theory utilized in child-centered play therapy followed by a discussion on the basic concepts of play therapy. The next session discusses the therapeutic process and the stages of play therapy and focuses on the therapist's role. The following section defines and explains limit setting and provides the four steps to follow in limit setting during play therapy. The next section looks at parental/guardian involvement, followed by a section that focuses on the outcomes of client-centered play therapy. A summary of the chapter follows.

Personality Theory

The theoretical development of child-centered play therapy evolves from the child's inner self of discovering who he/she is able to become. Three main concepts are based on the personality structure of child-centered play therapy: the person, the phenomenal field, and the self (O'Connor & Braverman, 1997; Landreth, 2002; Gumaer, 1984).

The person is everything the child is made of such as thoughts, behaviors, feelings, and physical appearance. The process of developing will never leave the person because he/she is always changing. When the child interacts and responds to his/her changes, it affects not just one change but multiple changes

within the child. The person is aiming towards self-actualization by being mature, having a positive attitude, developing independence, and growing and functioning positively. During this process the child's behaviors are goal directed to satisfy his/her personal needs experienced in his/her view of reality (O'Connor & Braverman, 1997; Landreth, 2002, Gumaer, 1984).

The phenomenal field is the second main concept of the child-centered theory of personality structure. This concept relates to all of the child's experiences including internal, external, conscious, or unconscious experiences. The child's perception of reality is vital to understand, especially when the therapist does not understand the child and the behaviors displayed. Again, the child's behaviors are identical to the "person" concept, which is goal-directed (O'Connor & Braverman, 1997; Landreth, 2002; Guamer, 1984). "The child's behavior must always be understood by looking through the child's eyes" (Landreth, 2002, p.62). The therapist does not judge or evaluate the child's thoughts or behaviors, but accepts the total child for who he/she is becoming.

The self is the third main concept in the child-centered theory of personality structure. This concept includes the child's interactions with others and the child's individual experiences. When the child combines those two experiences he/she is creating his/her own self. The child's total perceptions of him/her self is known as the self. The child's self is made up of abilities, perceptions, experiences, goals, and ideas in reference to his/her environment, peers, and family members. Usually the child's self concept is consistent with his/her behaviors. The child's need for positive self-regard from others begins to

develop through his/her self-awareness. The child begins to behave and think of others as he/she would want to be treated. Other factors that contributes to the child's need for self-regard are his/her satisfactions and frustrations (O'Connor & Braverman, 1997; Landreth, 2002; Guamer, 1984).

Child-Centered Play Therapy

Play has been defined as a "universal and inalienable right of childhood. Play is a child's central activity in childhood, occurring at all times and in all places. Children should not be pushed to play or be taught how to play. Play is spontaneous, enjoyable, voluntary, and nongoal-directed. Play provides children with an opportunity to gain a sense of mastery and control over their world as they explore and experiment with toys and other play materials" (Landreth, 2002, p.10). Adults sometimes refer to play as "child's work" to give some meaning to it, to make a comparison on how play fits into the adult world. Play, however, is the opposite of work. Work has some sort of goal and direction to it such as the completion of a task. In contrast, play is intrinsically motivated and changes to match the child's view of the world. For example, a child uses a folding table as a dog kennel (Web, 1991).

Children become familiar with their environment through the way they play. According to Piaget (1962), play brings together concrete experiences and abstract thought, and it is the symbolic function of play that is important. The one thing children have control and mastery of is their play, which allows them to feel more secure (Schaefer & O'Connor, 1983; Landreth, 2002).

Therapeutic Process of Play Therapy

The therapeutic process of play therapy allows the child to play out his/her scary, happy, and/or frightening feelings and problems (Axline, 1947; Landreth, 1993). Adults naturally communicate in therapy through conventional talk, whereas children communicate through play (Landreth, 1993). Children are not developmentally ready to use expressive language as a primary means of communicating their feelings (Landreth & Bratton, 1999) and struggle with abstract verbal reasoning, making it difficult for the therapist to use conventional talk therapy to help children talk through their feelings and problems (Kottman, 2001).

The child's method of displaying his/her emotional expressions is different than that of an adult, yet the feelings are similar, such as fear, anger, happiness, anxiety, or guilt. Therefore, "toys are viewed as the child's words and play as the child's language of activity. Play therapy is to children as counseling or psychotherapy is to adults" (Landreth & Bratton, 1999, p.2). The use of toys enables children to transfer anxieties, fears, guilt, and/or fantasies to objects rather than talk about them. A child's play can provide several different aspects about him/herself such as, "what the child has experienced, reactions to what was experienced, feelings about what was experienced, what the child wishes, wants, or needs, and the child's perceptions of him/herself" (Landreth & Bratton, 1999, p.4).

Axline (1947) viewed the process of play therapy as when a child played out feelings, thus bringing the feelings to the surface, getting them out in the open, facing them, and learning to either control or abandon them. It would seem then that play allows children to express themselves in a way that reduces tension and anxiety, thus allowing them to gain control of their lives.

According to Moustaka (1955) in child-centered play therapy, children process through five stages of the therapeutic process. In the first stage children convey and diffuse negative feelings in their play. In the second stage, children have unsure feelings, such as guilt or anxiety. In the third stage children once again express mainly negative feelings; however, the feeling are directed towards parents, siblings, or the therapist, or acted out through regressive behaviors. In the fourth stage the children's unsure negative and positive feelings return, and again these feelings are directed towards the parents, the siblings, or the therapist. In the last stage of child-centered play therapy, children mainly express clear, positive feelings, along with realistic negative attitudes expressed without ambivalence (Landreth, 2002).

The play therapist is a special individual in the child's life because he/she does not probe, teach, or direct the child during play therapy. The therapist simply verbalizes reflective statements of the child's present behavior(s) and natural urge toward self-direction.

Therapist's Role

In child-centered play therapy Axline (1947) developed eight basic principles which guide the therapist. They are useful possibilities when followed sincerely, consistently, and intelligently by the therapist. The principles are as follows:

1. The therapist must develop a warm, friendly relationship with the child, in which the good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he/she is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his/her feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him/her in such a manner that he/she gains insight into his/her behavior.
5. The therapist maintains a deep respect for the child's ability to solve his/her own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversations in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of

his/her responsibility in the relationship (p. 73-74).

When a therapist applies these eight basic principles the elements of warmth, empathy, genuineness, acceptance, and trust are being established between the child and therapist. For most children, the working alliance is like no other relationship they have experienced because the children are fully accepted and valued for who they are. The play therapist role is to be fully present, meaning interacting with the child by listening, observing, making reflective statements of recognition, acceptance, and caring. The play therapist creates a relationship that enables the child to discover how he/she can function independently (Landreth, Baggerly, & Tyndall-Lind, 1999).

A major component of child-centered play therapy is turning over the responsibility to the child, which fosters independence and empowerment (Landreth & Bratton, 1999). The therapist does not judge or evaluate the child; therefore, interpretations are not generally used. Another major component of child-centered play therapy is for the therapist to display acceptance and warmth to the child. This encourages the child to relax and become calm and comfortable enough to play out any emotions he/she is experiencing. When the therapist is accepting of who the child fully is the treatment outcomes tend to be more successful (Axline, 1947).

Limit Setting in Play Therapy

Setting limits in play therapy helps children experience how it feels to have choices and responsibilities. Limits usually are not expressed until they are

needed. Limits should be minimal, enforceable, and expressed assertively based on clear, definable criteria. For example, a therapist states, "I am not for hitting." According to Landreth (2002),

1. Limits provide physical and emotional security and safety for children.
2. Limits protect the physical well being of the therapist and facilitate acceptance of the child.
3. Limits facilitate the development of decision-making, self-control, and self-responsibility of children.
4. Limits anchor the session to reality and emphasize the here and now.
5. Limits promote consistency in the playroom environment.
6. Limits preserve the professional, ethical, and socially acceptable relationship.
7. Limits protect the playroom materials and room (p. 250-257).

Four specific steps are generally followed in the therapeutic limit setting. The steps were created to help understood, communicate, and accept the child's thoughts and behaviors. A therapist can remember the steps by the acronym ACT (Acknowledge, Communicate, Target) when limits need to be set. The first step is to verbally *acknowledge* the child's feelings, wishes, and wants. The importance of the first step is for the therapist to verbally acknowledge and accept the child's feelings which he/she is expressing in play therapy. When a child displays a feeling the therapist should immediately verbalize a reflective

statement to the child on that particular feeling. For example the therapist say, "You are frustrated with the puzzle" (Landreth, 2002, p.533).

In the second step the therapist *communicates* the limit and then reflects the child's desire at that particular moment. As mentioned above, the limits need to be minimal, enforceable, and expressed assertively based on clear, definable criteria. For example, the child is about to hit the doll house with the hammer and the therapist says, "The doll house is not for hitting with the hammer." and then reflects to the child, "You want to throw the hammer at the doll house" (Landreth, 2002).

The third step is *target* acceptable alternatives. The therapist makes available to the child multiple options in ways to replace the inappropriate thoughts and behaviors such as substituting objects, nonverbal cues, and/or more durable and safer objects. For example the therapist says, " The log is for hitting with the hammer." "The sink is not for standing on. You may choose to stand on the table or ladder" (Landreth, 2002).

The therapist needs to provide the child with the first three steps at a minimum of three times before the final stage is mentioned to the child. However, if the child is persistent on breaking the limits then the fourth step, stating final choice, is implemented. The therapist verbalizes to the child two different options. The first option could be placing the object(s) outside the playroom or having the object(s) in the playroom off limits for the remainder of that particular session. The second option could be ending the play therapy session at that particular moment and removing the child from the room. The

therapist must follow through with whatever decision the child decides. Even thought the child will probably act out negative behaviors and verbalize negative comments, this should not allow the therapist to make a different decision. When the therapist follows on the rules set, the child learns to take responsibility for her behaviors. For example the therapist might say, "If you choose to continue to try to hit the doll house with the hammer, you choose to either not play with the hammer or leave the play room for today" (Landreth, 2002).

Parental Involvement

It is important for parents/guardians to be involved in the therapeutic process of child-centered play therapy. The parental involvement includes intake interviews with the parents to obtain the background information of the child. The interviews provide knowledgeable information for the therapist to understand how the child interacts and behaves outside the play therapy room. This allows the therapist to be more empathetic, sincere, and genuine with the child, which will enhance the working alliance. Consent forms need to be signed by the child's parent(s) or guardian(s) before any therapeutic interventions can be provided to the child. The therapist can also involve the parent(s) or guardian(s) in the therapeutic process by spending a brief amount of time with them before or after each child's session and consulting with them about parenting skills and family interactions (Landreth, 2002).

Outcomes of Child-Centered Play Therapy

Play therapy is not necessarily a long-term process requiring several months or years of therapy. Many of the behavioral problems and experiences children have can be handled effectively in a relatively short length of time. Therapy is a gradual and continual process toward solutions to the problems or experiences. Therefore, the therapist does not need to inflict predetermine solutions onto the child in order to speed up the process of growth.

Ray, Bratton, Rhine, and Jones (2001) performed a meta-analysis of 94 research studies focusing on the efficacy of play therapy as a feasible psychotherapy intervention. They found play therapy to have a large positive effect on treatment outcomes with children. The results indicated play therapy was effective across modality, age, gender, clinical and nonclinical populations, settings, and theoretical schools of thought. Play therapy has also been demonstrated as an effective therapeutic approach for a variety of children's problems in the following areas: decrease in aggressive, acting out behaviors; improved emotional adjustment of abused and neglected children and children of divorced parents; decreased maladaptive school behaviors; improved self-concept; and many other children problems (Landreth, 2002).

Fall (1999) conducted a study focusing on the relationship of play therapy to self-efficacy. The study was conducted in school settings from three different school districts with a total of 62 children participated. Thirty-one children received six play therapy sessions and thirty-one children did not serve play therapy treatment. Three elementary school counselors provided the play

therapy interventions. All 62 children were measured on three scales prior to and following the intervention - a classroom observation, the Self-Efficacy Scale for Children (S-ES) and the Conners Teachers Rating Scale (CTRS). All counseling sessions were video taped to provide a fourth measure.

The results on the S-ES showed play therapy increased the children's self-efficacy, whereas for children who did not receive play therapy, their self-efficacy slightly decreased. The classroom observations and the CTRS showed both groups negative classroom behaviors decreased. For the videotaped sessions, a case study was presented. The subject received six child-centered play therapy sessions. After the child received all six play therapy sessions, the child's teacher reported he seemed to challenge himself longer on assignments and his academic grades improved. The child's self-efficacy scored improved 18 points; his classroom behavior improved nine points on the CTRS, and by 6 points on the classroom observation. His teacher stated he had increased his confidence, was more physical and interactive with peers and showed more emotional range (Fall, 1999).

Griffith (1997) ran a case study of a two-year girl who was sexually abused. She was referred for short-term child-centered play therapy treatment to help work through her sexual trauma. Problem-solving behaviors emerged when she used reasoning powers to draw on the Etch-A-Sketch and arrange doll furniture into a functional whole. The child took the initiative to be assertive by talking to the abuser on the telephone and told him to "Stop!" The child expressed increased self-esteem and empowerment during therapy. As a result,

play therapy helped the child to develop self-strength and self-awareness as a separate person (Griffith, 1997).

Bills (1950) investigated the effects of child-centered play therapy with children identified as slow readers. He discovered after six individual and three group play therapy session, the children who received play therapy showed improvements in their reading ability compared to the control group (Landreth, Baggerly, Tyndall-Lind, 1999).

Crow (1989) an elementary school counselor, tested ten 30-minute child-centered play therapy sessions with twelve first-grade students. The students were held back because of their low achievement in reading. Results indicated that the children's self-concepts significantly improved when compared to a matched control group. From what is known about the impact of a positive self-concept on academic learning, Crow's findings have tremendous significance, especially in view of the short-term nature of the study (Landreth, Baggerly, Tyndall-Lind, 1999).

Kot (1995) evaluated the effects of short-term, intensive, child-centered play therapy with children who had witnessed domestic violence and were temporarily at a women's shelter. Eleven children each received twelve individual 45-minute play therapy sessions in a timeframe of 14 to 21 days. A similar group of children at the women's shelter did not receive play therapy. The children who received play therapy scored significantly higher than the control group on self-concept, reduction of externalizing behavior problems, and

reduction of total behavior problems on standardized measures (Landreth, Baggerly, Tyndall-Lind, 1999).

Irwin (1971) examined a 16 year-old female hospitalized for schizophrenia. The girl would not make eye contact, stayed in bed all day, displayed no affect with only a blank stare, spoke only one word (yellow), and lacked bowel and bladder control. After two child-centered play therapy sessions, hospital staff began to notice a significant difference the child's behaviors. Once the girl received all six of her play therapy sessions she able to leave her room regularly, read aloud to patients, communicate verbally, make eye contact, display affection, and control her bowels and bladder (Landreth, 2002).

Oualline (1975) studied the effectiveness of child-centered play therapy by using the format of a control group and experimental group. The subjects consisted of twelve children ages four and six, who had an impairment in hearing and behavioral problems. Ten weekly, fifty minute play therapy sessions were given to the experimental group. Their scores were significantly higher on the social maturity scale when compared to the control group. The researcher believed child-centered play therapy is especially therapeutic for hearing impaired individuals because verbalization is not the focal point (Landreth, 2002).

Barlow, Landreth, & Strother (1985) conducted a case study using child-centered play therapy. The subject was a four-year old girl who was pulling out her hair then eating it (also known as trichotillomania). The environment the therapist created was the main factor in the therapeutic process. The child felt

enabled to express herself in a way that she had never felt before. The child's hair was beginning to grow and cover her head by the end of the seventh session. After the child's eight play therapy session, the visual results of her hair growing back provided significant evidence of the effectiveness of child-centered play therapy (Landreth, 2002).

Most children do not need time between session to process information obtained in a therapy session. Play therapy allows children to express and understand their world through play. Some children benefit from several play therapy sessions in a row. Studies shown positive outcomes on child-centered play therapy when the children's play therapy sessions are scheduled closer together rather than weeks apart (Fall, 1999; Oualline, 1975). Studies have also proven to be effective with twelve or fewer every day play therapy sessions (Bills, 1950; Crow, 1989; Griffith, 1997). Some findings have found two or three sessions of play therapy can help children cope with their feelings (Irwin, 1971; Barlow, Landreth, & Strother, 1985). Children develop coping skills to help them manage their emotions and adjust to more appropriate behaviors. Establishing a working alliance and having only a few sessions of play therapy can provide children with the opportunity to sort through problems and experiences and try to resolve them.

Summary

The theoretical development of child-centered play therapy evolved from the child's own personality. There are three main concepts to the theory - the

person, the phenomenal field, and the self. Play allows children to explore and experiment with a variety of different objects in their own personal world in reality or fantasy. The therapeutic process of play therapy allows the children to play out how they think and/or feel as verbalizing thoughts and feelings are differentiated. The five stages children process through during their therapeutic treatment are discussed along with the eight basic principles to help guide a therapist during treatment. Other major components of child-centered play therapy are also mentioned. Setting limits in play therapy helps children learn what it feels like to make choices and take responsibility. The acronym ACT (Acknowledge, Communicate, Target) reminds a therapist of the four steps involved in setting limits. Parental/ Guardian involvement in child-centered play therapy involves signing the consent and providing intake information such as background and insurance information. The therapist may also provide a brief discussion on parenting skills and family interaction to the parent(s)/guardian(s). The results of a variety of outcome studies demonstrate how child-centered play therapy provides the healing power and capacity to facilitate significant change in a child's life in a very short period of time.

The purpose of the present study was to investigate the effectiveness of child-centered play therapy using the BRIC as the testing instrument. The BRIC and the procedures of the study will be discussed in more detail in the next chapter.

CHAPTER III: METHODOLOGY

This chapter discusses the methodology used in this study. A description of the subjects and how they were chosen will be followed by a description of the instrumentation used. In addition, procedures, data collection and data analysis will be described. This chapter concludes with a discussion of the methodological limitations.

Subject Selection and Description

Subjects for this study were male and female students attending the Migisi Day Treatment Program at Marriage & Family Health Services in Eau Claire, Wisconsin, in the spring of 2004 who volunteered to participate in this study. A total of twelve subjects participated, two females and ten males. Subjects were elementary school aged students. The subjects were enrolled in the Migisi Day Treatment Program from 12:00 p.m. to 4:00 p.m. Monday through Friday. The subjects were randomly assigned to either the control or the experimental group. The control group did not receive an hour of child-centered play therapy. The experimental group received an hour of child-centered play therapy.

Instrumentation

The Behavior Rating Index for Children (BRIC) was used for this study. The BRIC consists of thirteen questions that inquire about the degree of the subject's behavioral problems. The thirteen behavioral problems the BRIC addresses consist of the following: 1) feels happy or relaxed; 2) hides his/her

thoughts from other people; 3) says or does really strange things; 4) does not pay attention when he/she should; 5) quits a job or task without finishing it; 6) gets along well with other people; 7) hits, pushes, or hurts someone; 8) gets along poorly with other people; 9) gets very upset; 10) compliments or helps someone; 11) feels sick; 12) cheats and 13) loses his/her temper. The raters responded to the thirteen questions based on a 5-point, Likert-type scale.

The BRIC was developed and validated in 1984, by Stiffman, Orme, Evans, Feldman, and Keeney. "The BRIC was designed as a rating scale to be used by individuals in a subject's environments-such as parents, teachers, other caretakers, and subjects themselves-to measure the degree of children's behavior problems. The measure is brief, easy to use, and can be used by various individuals to evaluate subjects of all ages. The ten behavioral oriented problems presented on the BRIC were chosen because the authors noticed these behaviors appeared repeatedly in previous research" (Fischer & Corcoran, 1994, p. 421).

When scoring the BRIC item numbers 1, 6, and 10, are omitted because they are not behavioral oriented items. The scores are changed into a potential range of 1 to 100 by adding up all the items scores, subtracting the total number of items (out of 10) that were completed on the BRIC, multiplying it by 100, and dividing by the total number of items that were completed on the BRIC times 4. A score of 30 on the BRIC is the cut off point for indicating severe behavioral problems. A score higher than 30 indicates severe behavioral problems and the possible need for treatment or additional treatment (Fischer & Corcoran, 1994).

The BRIC has fair internal consistency reliability, with alphas ranging from .60 to .70 ($p<.001$). The test-retest reliability of the BRIC over a 1-to 2-week period is .50 ($p<.001$). Concurrent validity for the BRIC was found to be .65 ($p<.001$), as established through correlation between children's scores as reported by parents and the children's treatment status either receiving or not receiving treatment for behavioral problems. Also, a correlation of .76 ($p<.001$) was found between the subjects' BRIC scores and the 118-item Child Behavior Checklist scores (Fischer & Corcoran, 1994).

Data Collection Procedures

Data was collected in the spring of 2004 at Marriage and Family Health Services in Eau Claire, Wisconsin, from male and female elementary students enrolled in the Migisi Day Treatment Program. There were a total of twelve children, ten males and two females, enrolled in the Migisi program. The study had a control group and an experimental group. Each of the twelve subject's first and last names was written on a small piece of paper. The paper was folded in half and placed into a brown paper lunch bag. The first six subjects drawn from the bag were assigned to the control group. The remaining six subjects in the bag were assigned to the experimental group.

Each rater was a Migisi staff member employed at Marriage and Family Health Services. The BRIC directions were read aloud to the raters and questions asked regarding the BRIC were answered. Each rater received two BRICs per subject. In the upper right hand corner of the BRIC each rater hand

wrote a one on the first BRIC meaning first observation and a two on the second BRIC meaning second observation.

The control group did not receive an hour of child-centered play therapy. Instead, they participated in an hour of the therapeutic Migisi Day Treatment Program. Subject's behaviors were observed and rated at two different times during the day treatment program by a rater using the BRIC. The first behavioral observation began at the start of day treatment and lasted for the next hour. Following that hour the rater completed the BRIC. Two hours later the same rater re-observed the subject's behaviors by completing the second BRIC. After the rater completed both observations and BRICs he/she placed the BRIC in the envelope labeled control group.

The experimental group was given an hour of child-centered play therapy. The subject's behaviors were observed and rated before and after their child-centered play therapy session. The first behavioral observation started at the beginning of day treatment then ended after an hour with a rater completing the BRIC. Then the subjects received an hour of child-centered play therapy and afterward returned to the Migisi day treatment group room. The second behavioral observation and completion of the BRIC occurred an hour after the subject returned to Migisi day treatment program. When the rater completed both observations and BRICs he/she placed the BRIC in the envelope labeled experimental group.

Data Analysis

The data for this study was analyzed using independent sample t-tests. Since there was no significant difference found on the pre-test between the experimental group and control group, it was not necessary to use the pre-test scores as covariates. The t-tests were used to find out if there were any statistically significant differences between the control and experimental groups' BRIC scores as well as the total score. The t-tests were performed on the total score and each of the ten BRIC questions that dealt with behavioral problems to analyze if there was a difference between the experimental and control group's post-test. The differences between the experimental group's and the control group's pre-test and post-test score were examined by t-tests. The means and standard deviations were also determined.

Limitations

One limitation to this study is the subjects that were used may not be representative of the children in other areas of the world and therefore the results should be used keeping that in mind. All subjects who participated in this study were attending Migisi Day Treatment Program and therefore the results should be used cautiously when generalizing to other Day Treatment Programs. The subjects were within a therapeutic milieu for four hours each weekday, which may have affected their behaviors. The subjects in the experimental group received only one, one hour session of child-centered play therapy session versus receiving multiple one hour sessions for a certain length of time. Lastly,

there has been limited research conducted on the BRIC; however, it has been shown to be reliable and valid.

CHAPTER IV: RESULTS

Introduction

This chapter will provide a summary of the data collected. A description of the statistics used to analyze the data will be given in table format. The research questions on the BRIC related to the behavioral observations of the control and experimental groups will be analyzed. For all appropriate statistical tests, a two-tailed test with an alpha level of .05 will be used.

Independent t-tests were conducted to compare differences between the experimental and control groups on all ten items of the BRIC and the total score and revealed no significant difference between the groups at the pre-test measure. As a result, using the pre-test scores as a covariate was not necessary.

Item Analysis

Ho1: There will be no statistically significant difference within the sample scores on the Behavior Rating Index for Children a). between a control group and an experimental group at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-test for, b) the experimental group nor, c) the control group.

A t-test for independent samples was conducted to determine whether a difference existed at post-test between the experimental and the control groups for the BRIC score total. Data analysis revealed a significant difference between the means for the control and experimental groups ($t=2.30$, $p=.044$), with

subjects having received play therapy (M=32.5) exhibiting fewer behavioral problems than subjects who had not received an hour of play therapy (M=59.58) (see Table 1). Therefore, null hypotheses Ho1:a was rejected. Although the BRIC total score went down 15.00 for the experimental group and up 6.67 for the control group, no significant difference were found between the pre-test and post-test means for the experimental group, (t=1.53, p=.186), nor the control group (t=.483, p=.649). As a result, the null hypotheses Ho1:b and Ho1:c were not rejected.

Table 1
t-test on Comparing the Total Scores Between the Control Group and the Experimental group

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	47.50	16.88	52.92	19.52	10	.514	.618
Post-Test	32.50	19.10	59.58	21.65	10	2.30	.044*
Change	15		-6.67				

* significant at p<.05

Ho2: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with hiding thoughts from other people at the post-test, nor will there be a significant difference in the

BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

A t-test for independent samples was conducted to determine whether a difference existed at post-test between the experimental and the control groups for behaviors with hiding thoughts from other people. Data analysis revealed no significant difference (t=1.65, p=.131) between the means for the control group (M=2.83) and experimental group (M=4.17) (See Table 1). No significant difference was found between pre-test and post-test means for the experimental group, (t=.439, p=.679), nor the control group (t=.255, p=.809). As a result, null hypotheses Ho2:a, Ho2:b and Ho2:c were not rejected.

Table 2
t-test on Behaviors With Hiding Thoughts From Other People Using the Control and Experimental Group as the Independent Variable

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	3.17	1.47	4.33	.516	6	1.83	.115
Post-Test	2.83	1.47	4.17	1.33	10	1.65	.131
Change	.33		.17				

Ho3: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with saying or doing really strange things at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

A t-test for independent sample was conducted to determine whether a difference existed at post-test between the experimental and control groups for behaviors with saying or doing really strange things. Data analysis revealed no significant difference ($t=1.67$, $p=.126$) between the means for the control group ($M=2.17$) and experimental group ($M=3.67$) (see Table 3). No significant difference was found between pre-test and post-test means for the experimental group, ($t=.674$, $p=.530$), nor the control group ($t=.146$, $p=.889$). As a result, null hypotheses Ho3:a, Ho3:b, and Ho3:c were not rejected.

Table 3
t-test on Behaviors With Saying or Doing Really Strange Things Between the Two Groups

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	2.50	1.38	3.50	1.52	10	1.20	.260
Post-Test	2.17	1.60	3.67	1.51	10	1.67	.126
Change	.33		-.17				

Ho4: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with not paying attention when he/she should at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor c) the control group.

A t-test for independent samples was conducted to determine whether a difference existed at post-test between the experimental and control groups for behaviors with not paying attention when he/she should. Data analysis revealed no significant difference (t=.773, p=.458) between the means for the control group (M=2.50) and experimental groups (M=3.17) (See Table 4). No significant differences was found between pre-test and post-test means for the experimental

group, (t=2.0, p=.102), nor the control group (t=.277, p=.793). As a result, null hypotheses Ho4:a, Ho4:b, and Ho4:c were not rejected.

Table 4
t-test on Behaviors With Not Paying Attention When He/She Should Between The Two Groups

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	3.17	.983	3.33	1.63	10	.214	.835
Post-Test	2.50	1.23	3.17	1.72	10	.773	.458
Change	.67		.17				

Ho5: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with quitting a job or task without finishing it at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

At-test for independent sample was conducted to determine whether a difference existed at post-test between the experimental and control groups for behaviors with quitting a job or task without finishing it. Data analysis revealed a significant difference between the means on behaviors with quitting a job or task without finishing it for the experimental and control groups (t=2.31, p=.043), with

subjects having received an hour of child-centered play therapy (M=2.00) exhibiting fewer behavioral problems than subjects who did not receive an hour of play therapy (M=3.83) (see Table 5). Therefore, null hypothesis Ho5:a was rejected. No significant differences was found between pre-test and post-test means for the experimental group, (t=1.94, p=.111), nor the control group (t=.756, p=.484). As a result, null hypotheses Ho5:b and Ho5:c were not rejected.

Table 5
t-test on Behaviors With Quitting a Job or Task Without Finishing it Between the Two Groups

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	3.00	1.41	3.17	1.47	10	.200	.845
Post-Test	2.00	1.10	3.83	1.60	10	2.31	.043*
Change	1.00		-.67				

* significant at p<.05

Ho6: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with hitting, pushing, or hurting someone at the post-test, nor will there be a significant difference

in the BRIC score from pre-test to post-post for, b) the play therapy group nor, c) the control group.

A t-test for independent sample was conducted to determine whether a difference existed at post-test between the experimental and control groups for behaviors with hitting, pushing, or hurting someone. Data analysis revealed no significant difference (t=1.00, p=.341) between the means for the control group (M=1.33) and experimental group (M=2.00) (see Table 6). No significant differences was found between pre-test and post-test means for the experimental group, (t=1.168, p=.296), nor the control group (t=.191, p=.856). As a result, null hypotheses Ho6:a, Ho6:b, and Ho6:c were not rejected.

Table 6
t-test on Behaviors With Hitting, Pushing, or Hurting Someone Between The Two Groups

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	1.83	1.17	1.83	1.17	10	.000	1.00
Post-Test	1.33	.516	2.00	1.55	10	1.00	.341
Change	.50		-.17				

Ho7: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with getting along poorly with

other people at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

A t-test for independent sample was conducted to determine whether a difference existed at post-test between the experimental and control groups for behaviors with getting along poorly with other people. Data analysis revealed no significant difference (t=1.52, p=.160) between the means for the control group (M=2.50) and experimental group (M=3.50) (see Table 7). No significant differences was found between pre-test and post-test means for the experimental group, (t=1.40, p=.220), nor the control group (t=.000, p=1.00). As a result, null hypotheses Ho7:a, Ho7:b, and Ho7:c were not rejected.

Table 7
t-test on Behaviors With Getting Along Poorly With Other People Between The Two Groups

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	3.67	1.37	3.50	1.05	10	-.237	.817
Post-Test	2.50	1.05	3.50	1.23	10	1.52	.160
Change	1.17		.00				

Ho8: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with getting very upset at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group norm, c) the control group.

A t-test for independent sample was conducted to determine whether a difference existed at post-test between the experimental and control groups for behaviors getting very upset. Data analysis revealed no significant difference (t=1.59, p=.143) between the means for the control group (M=3.17) and experimental group (M=4.33) (see Table 8). No significant differences was found between pre-test and post-test means for the experimental group, (t=.877, p=.421), nor the control group (t=.955, p=.383). As a result, null hypotheses Ho8:a, Ho8:b, and Ho8:c were not rejected.

Table 8
t-test on Behaviors With Getting Very Upset Between The Two Groups

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	3.83	.983	3.50	1.38	10	-.482	.640
Post-Test	3.17	1.33	4.33	1.21	10	1.59	.143
Change	.67		-.83				

Ho9: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with feeling sick at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

A t-test for independent sample was conducted to determine whether a difference existed at post-test between experimental and control groups for behaviors with feeling sick. Data analysis revealed no significant difference (t=.620, p=.549) between the means for the control group (M=1.67) and experimental group (M=1.33) (see Table 9). No significant differences was found between pre-test and post-test means for the experimental group, (2.00, p=.102), nor the control group (t=.000, p=1.00). As a result, null hypotheses Ho9:a, Ho9:b, and Ho9:c were not rejected.

Table 9
t-test on Behaviors With Feeling Sick Between The Two Groups

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	2.33	1.21	1.33	.516	6	-1.86	.107
Post-Test	1.67	1.33	1.33	1.21	10	-.620	.549
Change	.67		.00				

Ho10: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with cheating at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor c) the control group.

A t-test for independent sample was conducted to determine whether a difference existed at post-test between the control and experimental groups' behaviors with cheating. Data analysis revealed a significant difference on behaviors with cheating between the means on behaviors with cheating for the experimental and control groups (t=3.08, p=.012), with subjects having received an hour of child-centered play therapy (M=1.67) exhibiting fewer behavioral problems than the subjects who had not received therapy (M=3.67) (see Table 10). Therefore, null hypotheses Ho1:a was rejected. No significant difference were found between the pre-test and post means for the experimental group, (t=.000, p=1.00), nor the control group (t=.698, p=.516). As a result, null hypotheses Ho10:b and Ho10:c were not rejected.

Table 10
t-test on Behaviors With Cheating Between The Two Groups

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	1.67	1.21	3.00	1.67	10	1.53	.145
Post-Test	1.67	1.21	3.67	1.03	10	3.08	.012*
Change	.00		-.67				

* significant at p<.05

Ho11: There will be no statistically significant difference within the sample scores on the Behavioral Rating Index for Children a) between the control and experimental group's behaviors with losing his/her temper at the post-test, nor will there be a significant difference in the BRIC score from pre-test to post-post for, b) the experimental group nor, c) the control group.

A t-test for independent sample was conducted to determine whether a difference existed at post-test between the experimental and control groups for behaviors with losing his/her temper. Data analysis revealed no significant difference (t=1.48, p=.169) between the means for the control group (M=3.17) and experimental group (M=4.17) (see Table 11). No significant differences was found between pre-test and post-test means for the experimental group, (t=.877,

p=.421), nor the control group (t=.488, p=.646). As a result, null hypotheses Ho11:a, Ho11:b, and Ho11c were not rejected.

Table 11
t-test on Behaviors With Losing His/Her Temper Between The Two Groups

	Group						
	Experimental		Control				
Time	M	SD	M	SD	df	t	p
Pre-Test	3.83	.983	3.67	1.63	10	-.124	.835
Post-Test	3.17	1.33	4.17	.983	10	1.48	.169
Change	.67		-.50				

Summary

Overall, the results of this research suggest the following conclusions for the elementary students enrolled in the Migisi Day Treatment at Marriage and Family Health Services in Eau Claire, WI. Independent t-tests were conducted to compare differences between the experimental and control groups on all ten items of the BRIC and the total score and revealed no significant difference between the groups at the pre-test measure. As a result, using the pre-test scores as a covariate was not necessary.

Three of the eleven hypotheses were rejected. The first hypothesis rejected stated there is no statistically significant post-test difference within the sample scores on the Behavioral Rating Index for Children between the control

and experimental groups. Subjects who received an hour of play therapy showed a significant difference of behavioral problems between their pre-test and post-test scores than did their counterparts who did not receive therapy. The experimental group decreased their behavioral problems by 15.000 compared to the control group, which increased by 6.67 (see Table 1).

The second hypothesis rejected stated there is no statistically significant post-test difference between the control and experimental group's behaviors with quitting a job or task without finishing it. Subjects who received an hour of client-centered play therapy revealed a significant post-test difference existed for quitting a job or task without finishing it as compared to the control group (see Table 5).

The final hypothesis rejected stated there is no statistically significant post-test difference between the control and experimental group's behaviors with cheating. The data analysis also revealed the experimental group scored significantly lower on their post-test for cheating (see Table10). The remaining eight hypotheses were not rejected.

The present study used independent t-tests to analyze the data based on ten times of the BRIC and total score. The results were displayed in table format. (see tables). A discussion of the results, conclusions, implications, and recommendations from this research will be discussed in more detail in the next chapter.

CHAPTER V: DISCUSSION

Summary

This chapter provides a discussion of the results and conclusions that can be drawn from this research. Implications for the research findings will also be addressed, followed by recommendations for future research.

In summary, play therapy has been used in different treatment modalities for centuries. Although the treatment goals and objectives to each style of play therapy are different, children have always acted out their thoughts and behaviors in the therapy room. This paper examined previous research regarding the theoretical development and three main concepts of the personality structure of child-centered play therapy (O'Connor &Braverman, 1997; Landreth, 2002; Gumaer, 1984). Child-centered play therapy's basic concepts, therapeutic process, and five stages of play therapy were addressed (Landreth, 2002; Web, 1991, Schaefer & O'Connor, 1983; Axline, 1947; Landreth, 1993; Landreth & Bratton, 1999; Kottman, 2001; Moustaka, 1955). The therapist's role of fully accepting the child for who he/she is and not setting limits until they are needed were discussed (Axline, 1947; Landreth, Baggerly, & Tyndall-Lind, 1999; Landreth & Bratton, 1999; and Landreth, 2002). The importance of parental/guardian involvement was explored (Landreth, 2002). A variety of outcomes on short-term child-centered play therapy and their effectiveness were examined (Ray, Bratton, Rhine, & Jones, 2001; Fall, 1999; Griffith, 1997; Bills, 1950; Crow, 1989).

The purpose of this study was to measure the effectiveness of child-centered play therapy. A total of twelve elementary students, ten males and two females, from the Migisi Day Treatment Program at Marriage and Family Health Services in Eau Claire, Wisconsin, participated in the study. The Behavior Rating Index for Children (BRIC) was used as the testing instrument. The BRIC gathers the subject's observational behavioral problems at a specific time with thirteen likert type questions. The control group (n=6) did not receive an hour of child-centered play therapy; however subjects were observed and rated at two different times with two hours in between each rating in the day treatment program milieu. The experimental group (n=6) received an hour of child-centered play therapy and the BRIC was completed right before the play therapy and an hour after the play therapy.

Data analysis found there were three significant differences between the experimental and control groups at the post-test measure. Subjects who received an hour of client-centered play therapy showed a significant difference of behavioral problems between their pre-test and post-test scores on the BRIC compared to the subjects who did not receive an hour of child-centered play therapy. The experimental group decreased their total score by 15.00 whereas the control group increased by 6.67. The second significant difference found between the two groups dealt with the subject's quitting a job or task without finishing it. The subjects who received an hour of child-centered play therapy spent twenty-five percent of the time quitting a job or task without finishing it while the control group spent fifty percent of the time quitting a job or task without

finishing it. The final significant difference found between the control and experimental groups was with cheating behaviors. The experimental group spent zero to five percent of their time cheating on games, activities, and written assignments and the control group spent fifty to hundred percent of their time cheating.

No significant differences were found between the pre-test and post-test measures for any of the ten items on the BRIC or for the total score for either group. As a result, using the pre-test scores as a covariate was not necessary. Also, no significant differences were found between the control and experimental subject's behavioral problems with hiding thoughts from other people, saying or doing really strange things, not paying attention when he/she should, hitting, pushing, or hurting someone, getting along poorly with other people, getting very upset, feeling sick, and losing his/her temper.

Conclusions

This particular study found a significant difference existed at the post-test means for the experimental and control groups' for the BRIC score. The subjects who received an hour of child-centered play therapy exhibited fewer behavioral problems than subjects who did not receive an hour of child-centered play therapy. The experimental group decreased their behavioral problems by 15.00 compared to the control group, which increased by 6.67. This seems to imply that an hour of child-centered play therapy helped the subjects control their behavioral problems upon returning to the day treatment milieu.

During the children's child-centered play therapy session, the play therapy relationship had minimal limits. Messiness was accepted, exploration was encouraged, and neatness or doing something in a particular way was not required of the children. The therapist did not set or address limits until they were needed. When limits were set it may have helped the children use self-control skills. For example: one subject attempted to pour the dirty paint water onto the floor. The therapist stated assertively to the child, "You would like to pour the paint water onto the floor, but the floor is not for pouring the paint water on. The pan on the desk is for pouring the paint water into." This allowed the subject to stop him/herself because the child's feelings were recognized, communicated what the floor was not for, and provided an acceptable alternative. Having limits provided consistency and predictability in helping children feel safe.

Another implication may be the experimental subjects enjoyed playing, saying, and/or acting out their behaviors, thoughts, and feelings in ways they are not allowed in the day treatment milieu. During the play therapy session, the therapist accepted all of the subject's feelings, desires, and wishes communicated verbally and nonverbally; which may have increased the process of change. Self-directed play allowed the children the opportunity to be themselves because it was safe and did not pressure them to change.

In the child-centered play therapy session, the children were the leaders in play and the therapist was the follower, which might have been an essential part of the experimental group's decrease on their post-test score. The therapist main focus was on the children. The therapist provided warmth and understanding by

making reflective statements of recognition. Throughout the play therapy session the therapist communicated warmth, acceptance, genuineness and respect so that the children may begin to achieve feelings of security, adequacy, and worthiness. In client-centered play therapy, children always communicate through their bodies, play, and total selves. The therapist did not become actively involved until the children initiate the play. The role of therapist was to let the children discover how to function independently. Having the children be the leader of the play therapy session allowed for them to feel in control and powerful over the therapist.

The post-test analysis found a significant difference between the two groups behaviors on cheating. This may suggest the experimental subjects felt more confident in themselves during games, activities, and written assignments. This may also imply the subjects were trying to be good role models towards their peers. A successful decrease on the post-test for the experimental subject's may have been a result of the warm and friendly working alliance established between the experimental subjects and therapist.

The children may have felt the child-centered play therapy session was a successful and exciting experience. From their therapy session the children may have gained a sense of respect and value for themselves. The therapy session might have encouraged the children to accept themselves, assume responsibility, and offer tolerance in working towards all of their capabilities. And in turn the children may have applied those qualities and abilities to their relationships with others after they returned to the day treatment milieu.

The final significant difference found on the measure for the experimental and control groups was between the groups' behavior on quitting a job or task without finishing it. This finding may propose the experimental subjects had an increase in self-confidence, patience, and responsibility. It may also suggest the subjects enjoyed the job or task they were completing. This may also hint at the subjects wanted to receive four points for that particular activity. For each activity during day treatment the subjects can receive up to four points and as few as zero points.

According to Axline (1947) when child-centered play therapy techniques are applied to treatment with children, the results are extremely significant. In the play therapy session, the therapist did not attempt to hurry the therapy along. In child-centered play therapy, the therapist recognizes the session as a gradual process. As the therapist allows the children to take their time, he/she will be rewarded for his/her patience later on in the treatment.

During the play therapy session the children were given the opportunity to relieve tensions and pressures affecting them. In the play therapy session it was a time in which the children were not hurried or prodded along. The children could feel relaxed, calm, and safe. If the children wanted to keep their mouths closed or roll clay all session they could. The children were allowed to follow and explore their heart and mind. The relationship established by the children and therapist may have made it possible for the children to reveal their real self to the therapist and have it accepted by him/her. The experimental subject's self-

confidence may have begun to slowly develop due to the therapist's acceptance of their total selves causing a decrease on the post-test score.

The other eight of eleven BRIC questions dealt with other specific behavioral problems towards others and themselves. Perhaps the subjects acted out because of the personal issues going on at home or at school. The results may have been different if the children's home and school environment were stable and had they not seen the killing and fighting in the movie. The small sample size used in this study may have skewed the pre-test and post-test scores. Only allowing the experimental group one hour of child-centered play therapy may not have had provided a strong effect on the children's behavioral problems since they are already in a therapeutic milieu.

Recommendations

Recommendations for therapists' utilization of child-centered play therapy with children who are struggling with for a variety of issues and further research on the effectiveness of child-centered play therapy will be addressed. New child-centered play therapy counseling techniques can be developed to assist children who are afflicted with a low self-esteem, behavioral problems, abuse, and/or trauma. This current study found three significant differences between the two groups' change and post-test scores in regards how the subjects behavioral performed.

As a result, it is recommended that child-centered play therapy be used with children who have difficulties in the area of self-concept, cognitive ability, and behavioral change. It is also suggested that child-centered play therapy be

used with children who struggle with anger management skills along with manic, depressed, and/or neglected children. Offering child-centered play therapy may prevent the children from quitting a job or task without finishing it.

Another recommendation is that child-centered play therapy be used with children who have difficulties in the areas of sportsmanship, honesty, and self-confidence. As found in this study, child-centered play therapy may help reduce children's cheating behavior. Minimal limitations in child-centered play therapy allow for the children to have a sense of direction, power, and control throughout their therapy session, which may help children feel less of a need to engage in cheating behavior.

The toys in the play room may have benefited the experimental subject's post-test scores. The therapeutic environment might have been comfortable and inviting for the experimental subjects due to the assortment of toys in the play room. In the child-centered play therapy sessions, the play therapy children played with toys that aided in exploration of real life experiences, expression of a wide range of feelings, testing of limits, expressive and exploratory play, exploration and expression without verbalization, and success without prescribed structure. Many of the play therapy children had poor self-concepts and were overly dependent and the play materials may have allowed and/or helped the children to express themselves. The experimental subjects may have been able to express their feelings and behaviors more comfortably through their play. Therefore the play toys and materials used in child-centered play therapy may be

an essential therapeutic variable. It is suggested that child-centered play therapy be used with children struggling with grief and family violence.

In each child-centered play therapy session the symbolic function of play might have allowed the play therapy children to explore and express their inner world. Their representation and use of the play materials may have enabled the children to transfer anxieties, fears, phobias, fantasies, and guilt onto objects rather than the therapist. The play therapy children played and/or acted out their behaviors, thoughts, and feelings rather than verbalizing them to the therapist. The selection of toys may have also encouraged the experimental subjects to immerse themselves into a safe and familiar environment to express and play out their modes of expressions. The play therapy subjects appeared to be able to communicate a wide range of feelings and behaviors with a limited amount of play materials which may have been an advantage to a decrease in the post-test score. As a result, it is recommended that child-centered play therapy be used with fearful anxious children.

Another possible suggestion, which may have benefited the experimental group, might have been in their child-centered play therapy session, the play therapy children were safe from their feelings and reactions because they were able to distance themselves from the traumatic event(s) and experience(s). The therapists noticed themes were played out repeatedly. Sometimes the play therapy children used the same toy until a new response to the conflict began to emerge. Child-centered play therapy children symbolically acted/played out an actual traumatic event(s) and/or experience(s) that had happened to them in the

past or present. After a couple of sessions the children positively changed or reversed the ending of the traumatic event(s) and/or experience(s). This symbolic experience may have facilitated children to begin to reach toward their inner resolution in helping them cope and adjust to problems. As a result, a further suggestion would be to use child-centered play therapy with sexually abused and/or traumatized children.

The empowering techniques used by the therapist may have relieved the emotional distress on the play therapy subjects such as through their use of a variety of expressive play therapy materials and their imaginations. The effectiveness of the hands-on activities, activity-based, and playful situations created and offered in the play room may have reinforced the experimental subject's behaviors upon returning to the day treatment milieu. It appeared when the play therapy children were given a safe, inviting, caring, and trusting environment, they had the ability to solve their own problems/issues. As a result, it is recommended child-centered play therapy be used with children who have a low sense of self-esteem.

Another suggestion could be to encourage self-esteem development to be incorporated into the school and day treatment program curriculums. Society should be more informed about the way that children who are receiving therapy are being discriminated against and begin to develop ways to rid society of unjust discrimination. It is suggested society needs to redefine what is desirable and what is therapy before children can begin to accept and think of therapy as a helping tool to their problems and/or experiences.

This particular study only researched a small population of elementary students, ten males and two females, enrolled in the Migisi Day Treatment Program at Marriage & Family Health Services, in Eau Claire, Wisconsin. One recommendation when replicating this study would be to use a broader pool of subjects. Wider age range, different areas of the state, or country could be helpful to get a result that can be generalized to the general public, not just elementary Day Treatment students. It would also be beneficial to see if the results of the study would be different among different age groups such as comparing elementary, middle, and senior-high aged-students in regards to their behavioral problems. A sample study of subjects with a wide age range may be useful in determining the effectiveness of child-centered play therapy. Perhaps it would help clarify if child-centered play therapy is out grown as one grows older.

Another suggestion would be use a pre-test post-test design, giving an hour of child-centered play therapy to the control and experimental groups and completing the BRIC an hour after the play therapy. Then later that evening such as before the subject goes to bed have the parent/guardian complete the BRIC, to see how the two groups change over time. Perhaps, some of the results of this study were not found to be significant due to the chance that the subjects may hide certain issues going on in their various environments. Elementary students who are not in therapy or have never received therapy treatment for their behavioral problems may have a lower level of confidence in themselves and may have poor problem-solving skills. By using a pre-test and post-test design with elementary male and female subjects who have and have not

received child-centered play therapy in the past one may find a significant difference in scores.

Possibly, a study could be done comparing child-centered play therapy to individual attention and having the duration for both groups identical. Perhaps by comparing the child-centered play therapy treatment to individual attention treatment would answer some of the unknown questions regarding the effectiveness and/or the importance of the working alliance of child-centered play therapy

This research suggests that the experimental groups' behavioral problems were significantly different at the post-test measure for the total score, quitting a job or task without finishing it, and cheating. This is an interesting finding that may suggest children need more than an hour of a child-centered play therapy session. It may also indicate that because the children are already in a therapeutic setting it might affect their behavioral problems at that particular moment. This could also imply that the behavioral problems of children have already decreased in response to their school or home environments since they are exposed to them everyday.

Perhaps, an international study comparing the effectiveness of child-centered play therapy may lead to significant findings. Comparing child-centered play therapy sessions from a country where children are not exposed to therapeutic treatment on a daily basis to the children in the United States who are given the opportunity may provide answers to some of the questions regarding the effectiveness of child-centered play therapy. One last

recommendation would be to involve parents'/guardians' perceptions of the outcomes of play therapy. This would examine whether behavioral changes seen within the play therapy room are generalized to the child's outside milieu. Utilizing parental/guardian figures to the fullest does seem to be more efficient and increases the probability of play therapy success.

There are many avenues in which to better the current study. Those mentioned above are just a few of the many that are possible. Case studies and outcomes have generally been used to study the effectiveness of child-centered play therapy. The efficacy of child-centered play therapy has been found to have significant effects on self-efficacy and locus of control of behaviors. However, the literature and this study found mixed results on the effectiveness of child-centered play therapy. Even though the field of play therapy is growing there is still a need for more research into the area of effectiveness of child-centered play therapy.

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